

Janet T. Mills
Governor

Jeanne M. Lambrew, Ph.D.
Commissioner



Maine Department of Health and Human Services
Maine Center for Disease Control and Prevention
11 State House Station
220 Capitol Street
Augusta, Maine 04333-0011
Tel: (207) 287-5500; Toll Free: (888) 664-9491
TTY: Dial 711 (Maine Relay); Fax (207) 287-5470

Request for Medication to End My Life in a Humane and Dignified Manner

Part One: Declaration of Patient

I, _____, am an adult of sound mind and am a resident of the State of Maine and have been since _____ (month) of _____ (year) and I am suffering from _____, which my attending physician has determined is a terminal disease and which has been medically confirmed by a consulting physician.

I have been fully informed of my diagnosis and prognosis, the nature of the medication to be prescribed and potential associated risks, the expected result and feasible alternatives, including palliative care and comfort care, hospice care, pain control and disease-directed treatment options.

I request that my attending physician prescribe medication that I may self-administer to end my life in a humane and dignified manner and contact any pharmacist to fill the prescription.

INITIAL ONE:

_____ I have informed my family of my decision and taken their opinions into consideration.

_____ I have decided not to inform my family of my decision.

_____ I have no family to inform of my decision.

I understand that I have the right to rescind this request at any time.

I understand the full import of this request, and I expect to die when I take the medication to be prescribed. I further understand that, although most deaths occur within 3 hours, my death may take longer and my physician has counseled me about this possibility.

I make this request voluntarily and without reservation, and I accept full moral responsibility for my actions.

Signature	Date
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Part Two: Declaration of Witnesses

By initialing and signing below on or after the date the person named above signs, we declare that the person making and signing above request:

Initials of Witness 1:

- _____ 1. Is personally known to us or has provided proof of identity;
- _____ 2. Signed this request in our presence on the date of the person's signature;
- _____ 3. Appears to be of sound mind and not under duress, fraud, or undue influence; and
- _____ 4. Is not a patient for whom either of us is the attending physician.

Witness 1 Print name	Signature	Date
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Initials of Witness 2:

- _____ 1. Is personally known to us or has provided proof of identity;
- _____ 2. Signed this request in our presence on the date of the person's signature;
- _____ 3. Appears to be of sound mind and not under duress, fraud, or undue influence; and
- _____ 4. Is not a patient for whom either of us is the attending physician.

Witness 2 Print name	Signature	Date
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NOTE: One witness must be a person who is not a relative by blood, marriage, or adoption of the person signing this request, is not entitled to any portion of the person's estate upon death and does not own or operate or is not employed at a health care facility where the person is a patient or resident. The person's attending physician at the time of the request is signed may not be a witness. If the person is an inpatient at a long-term care facility, one of the witnesses must be a licensed healthcare provider designated by the facility; the facility's designee may be an owner, operator, or employee of the health care facility.

To the person signing this request:

Give this completed form to your attending physician. Request a copy to keep for yourself.

To the attending physician:

Retain this completed original form in the patient's medical record. Provide a copy to the State Registrar, Office of Data, Research, and Vital Statistics.

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Form of Interpreter Attachment

I, _____, am fluent in English and _____
(language of patient)

On _____ (date) at approximately _____ (time) I read the "REQUEST FOR MEDICATION TO END MY LIFE IN A HUMANE AND DIGNIFIED MANNER" to _____ (name of patient) in _____ (language of patient).

Mr./Ms. _____ (name of patient) affirmed to me that he/she understands the content of this form, that he/she desires to sign this form under his/her own power and volition and that he/she requested to sign the form after consultations with an attending physician and a consulting physician.

Under penalty of perjury, I declare that I am fluent in English and _____ (language of the patient) and that the contents of this form, to the best of my knowledge, are true and correct.

Executed at _____ (city, county, and state)
on _____ (date).

Interpreter's signature: _____

Interpreter's printed name: _____

Interpreter's address: _____

NOTE: The interpreter must be a person who is not a relative of the patient by blood, marriage or adoption; a person who at the time the patient signs the *Request for Medication to End My Life in a Humane and Dignified Manner* would be entitled to any portion of the estate of the patient upon death, under any will or by operation of any law; or an owner, operator or employee of a health care facility where the patient is receiving medical treatment or is a resident.

To the interpreter: Give this completed form to the attending physician.

To the attending physician: Retain the original form in the patient's medical record. Mail a copy to the attention of the State Registrar, Office of Data, Research, and Vital Statistics.

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Attending Physician End-of-Life Reporting Form

PLEASE PRINT

A		PATIENT INFORMATION	
	PATIENT'S NAME (LAST, FIRST, MI)	DATE OF BIRTH	
	MEDICAL DIAGNOSIS AND PROGNOSIS		
B		PHYSICIAN INFORMATION	
	NAME (LAST, FIRST, MI)	TELEPHONE	
	MAILING ADDRESS		
	CITY, STATE, ZIP		
	CONSULTING PHYSICIAN NAME	TELEPHONE	
C		ACTION TAKEN TO COMPLY WITH LAW	
	1. FIRST ORAL REQUEST		
	<input type="checkbox"/> The patient made an oral request for medication to be self-administered for the purpose of ending the patient's life in a humane and dignified manner.	DATE	
	Comments:		
	2. SECOND ORAL REQUEST (Must be made 15 days or more after the first oral request.)		
	Indicate compliance by checking the boxes.		DATE
	<input type="checkbox"/> 1. The patient made a second oral request for medication to be self-administered for the purpose of ending the patient's life in a humane and dignified manner.		
	<input type="checkbox"/> 2. Attending physician has offered the patient an opportunity to rescind the request.		
	Comments:		
	3. WRITTEN REQUEST (Must be made 15 days or more after the first oral request.)		
	<input type="checkbox"/> The patient made a written request for medication to be self-administered for the purpose of ending the patient's life in a humane and dignified manner.	DATE	
Comments:			

4. ATTENDING PHYSICIAN DETERMINATIONS AND ACTIONS							
<p>Indicate compliance by checking the boxes.</p> <p>I have determined that the patient:</p> <div style="margin-left: 20px;"> <input type="checkbox"/> is at least 18 years of age; <input type="checkbox"/> is suffering with a terminal disease; <input type="checkbox"/> is competent; and <input type="checkbox"/> has made a voluntary request for medication to self-administer for the purpose of ending the patient's life in a humane and dignified manner. </div> <p>I have requested that the patient:</p> <div style="margin-left: 20px;"> <input type="checkbox"/> demonstrate he/she is a Maine state resident, and I am satisfied the patient is a Maine state resident. </div> <p>To ensure the patient is making an informed decision, I have informed the patient of the following:</p> <div style="margin-left: 20px;"> <input type="checkbox"/> the patient's medical diagnosis; <input type="checkbox"/> the patient's prognosis; <input type="checkbox"/> the potential risks associated with taking the medication to be prescribed; <input type="checkbox"/> the probable result of taking the medication to be prescribed; and <input type="checkbox"/> the feasible alternatives to taking the medication to be prescribed, including palliative care and comfort care, hospice care, pain control and disease-directed treatment options. </div> <p>I have taken the additional following steps:</p> <div style="margin-left: 20px;"> <input type="checkbox"/> Referred the patient to a consulting physician for medical confirmation of the diagnosis and for a determination that the patient is competent and acting voluntarily; <input type="checkbox"/> Confirmed that the patient's request does not arise from coercion or undue influence by another individual by discussing with the patient, outside the presence of any other individual, except for an interpreter, whether the patient is making an informed decision; <input type="checkbox"/> Verified that the patient, based on my evaluation or following a referral for counseling, is not suffering from a psychiatric or psychological disorder or depression causing impaired judgement; <input type="checkbox"/> Recommended that the patient notify the patient's next of kin; <input type="checkbox"/> Counseled the patient about the importance of having another person present when the patient takes the medication prescribed, and counseled the patient about not taking the medication prescribed in a public place; <input type="checkbox"/> Informed the patient that the patient has the opportunity to rescind the request at any time and in any manner; and <input type="checkbox"/> Verified immediately before writing a prescription for life-ending medication that the patient is making an informed decision. </div>							
D MEDICATION PRESCRIBED AND INFORMATION PROVIDED TO PATIENT							
<p>To be prescribed no sooner than 48 hours after the date of the written request.</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 70%; padding: 5px;"> <p>MEDICATION PRESCRIBED AND DOSAGE:</p> </td> <td style="width: 30%; padding: 5px;"> <p>DATE PRESCRIBED</p> </td> </tr> <tr> <td colspan="2" style="padding: 5px;"> <p>NAME OF PHARMACIST AND ADDRESS (if applicable)</p> </td> </tr> <tr> <td style="padding: 5px;"> <p>DATE DISPENSED AND TO WHOM</p> </td> <td style="padding: 5px;"> <p>DATE DISPENSED</p> </td> </tr> </table>		<p>MEDICATION PRESCRIBED AND DOSAGE:</p>	<p>DATE PRESCRIBED</p>	<p>NAME OF PHARMACIST AND ADDRESS (if applicable)</p>		<p>DATE DISPENSED AND TO WHOM</p>	<p>DATE DISPENSED</p>
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<p>NAME OF PHARMACIST AND ADDRESS (if applicable)</p>							
<p>DATE DISPENSED AND TO WHOM</p>	<p>DATE DISPENSED</p>						
E MEDICAL COVERAGE/PATIENT INSURANCE							
<p>What is the principal source of medical coverage for the patient?</p> <div style="margin-left: 20px;"> <input type="checkbox"/> a) Private Insurance <input type="checkbox"/> b) Government Payor includes Medicare, Indian Health Service, or CHAMPUS <input type="checkbox"/> c) Mainecare or Medicaid <input type="checkbox"/> d) Self Pay <input type="checkbox"/> e) None <input type="checkbox"/> f) Unknown </div>							

To the best of my knowledge, all of the requirements of the Death with Dignity Act, 22 M.R.S. chapter 418, have been met.	
PHYSICIAN'S SIGNATURE	DATE

If comments in any section exceed the space provided, please use an attached page. Supplemental comments should be identified using the appropriate alphanumeric notation (e.g., C3). **Retain the original form in the patient's medical record. Provide a copy of the completed form to the State Registrar, Office of Data, Research, and Vital Statistics within 30 days of writing the prescription.**

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Consulting Physician End-of-Life Care

PLEASE PRINT

A PATIENT INFORMATION	
PATIENT'S NAME (LAST, FIRST, MI)	DATE OF BIRTH

B REFERRING/ATTENDING PHYSICIAN INFORMATION	
NAME	TELEPHONE NUMBER

C CONSULTING PHYSICIAN DETERMINATIONS	
<p>I examined the above-named patient on _____ (date) at _____ (time). I have also reviewed the patient's relevant medical records.</p> <p>By checking below, I confirm the attending physician's diagnosis that the patient is suffering from a terminal disease, specifically _____ (list diagnosis), and verify that the patient is competent, is acting voluntarily, and had made an informed decision:</p> <p><input type="checkbox"/> a) diagnosis that patient is suffering from a terminal disease; <input type="checkbox"/> b) patient is competent; <input type="checkbox"/> c) patient is making an informed decision; <input type="checkbox"/> d) patient is acting voluntarily in his/her request for medication to end his/her life in a humane and dignified manner.</p>	

D CONSULTING PHYSICIAN'S INFORMATION	
NAME (please print)	LICENSE NUMBER
MAILING ADDRESS	
CITY, STATE, ZIP	TELEPHONE NUMBER
PHYSICIAN'S SIGNATURE	DATE

To the consulting physician: Provide the completed form to the attending physician.

To the attending physician: Provide a copy of the completed form to the State Registrar, Office of Data, Research, and Vital Statistics. Retain the original in the patient's medical record.

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End-of-Life Closure Form

Dear Physician:

Pursuant to the Department of Health and Human Services' authority to collect information under the **Death with Dignity Act**, 22 M.R.S. chapter 418, the Department requires physicians who write a prescription for medication for a patient to self-administer for the purpose of ending the patient's life in a humane and dignified manner to complete this follow-up form within **30 calendar days** of a patient's death, if known to the physician.

For the Department of Health and Human Services to accept this form, it must be signed by the Attending Physician, whether or not he or she was present at the patient's time of death.

This form should be mailed to the attention of the State Registrar at: 220 Capitol Street, 11 State House Station, Augusta, Maine, 04330. *All information is kept strictly confidential.* If you have any questions, call: 207-287-5459.

Patient's Name: _____ DOB: ____/____/____

Name of Attending Physician: _____

Prescription Record

Did the patient die from ingesting the lethal dose of medication, from their underlying illness, or from another cause such as terminal sedation or ceasing to eat or drink? **If unknown, please mark the form indicating that.**

- ☐ 1. Patient Choice (self-administered medication)
- ☐ 2. Underlying illness
- ☐ 3. Unknown
- ☐ 4. Other (please specify): _____
- ☐ 5. It has been six months since the prescription was written on _____ (date) and the death has not occurred or confirmed.

How was the unused medication disposed of? If unknown, please indicate the same.

Attending Physician Signature: _____

Date: ____/____/____